3 Essential Care Guidelines

3.1   Introduction

3.1.1   General Policy

This section covers all Medicaid services provided by rural health facilities and district health departments, as deemed appropriate by the Department of Health and Welfare (DHW). It addresses the following:

- Claims payment.

- Prior authorization (PA).

- Essential care providers program policy.

- Rural health clinic services.

- District health departments.

- Electronic claims billing.

- Paper claims billing.

3.1.2   Payment

Rural health clinics are paid an all-inclusive rate for each participant encounter.

The maximum allowable rate for rural health clinics is established by the Medicare intermediary.

District health departments are paid on a fee-for-service basis. Payment is the lower of the usual or customary charge, or the Medicaid fee schedule.

Check eligibility to see if the participant is enrolled in Healthy Connections (HC), Idaho's Medicaid primary care case management (PCCM) model of managed care. If a participant is enrolled, there are certain guidelines that must be followed to ensure reimbursement for providing Medicaid-covered services.

See *Section 1.5 Healthy Connections (HC), General Provider & Participant Information*, for more information.

3.1.3   Prior Authorization (PA)

Rural health clinic services do not require PA.

3.2   Essential Care Policy – Rural Health Clinics

3.2.1 Overview

Medicaid covers rural health clinic physician services including required supervision of nurse practitioners, physician assistants, and any required supplies incidental to a physician's professional services. Medicaid also covers the services of physician assistants, nurse practitioners, nurse midwives, clinical social workers, clinical psychologists, and specialized nurse practitioners, and any required supplies incidental to their services. There is no Medicaid coverage for dental services provided in rural health clinics.

3.2.2 Excluded Services

3.2.2.1   Laboratory

If an outside lab instead of the clinic performs a laboratory service, the outside lab must bill Medicaid directly. Laboratory services performed in rural health clinics are included in the encounter rate and cannot be billed to Medicaid.

3.2.2.2   Pharmacy

Over-the-counter (OTC) pharmaceuticals are not covered by Medicaid, with the exception of those OTC items identified as payable in *Section 3 Pharmacy Guidelines*. Pharmaceutical services for take home prescription medications will be covered under the Medicaid Pharmacy Program. Claims must be submitted to Medicaid on the pharmacy claim form under the pharmacy's provider number. Pharmaceutical services may not be billed as an encounter.

3.2.3 Encounter Definition

An encounter is defined as a face-to-face contact for the provision of medical or mental services between a clinic patient and a physician, physician assistant, nurse practitioner, clinical social worker, clinical psychologist, or other specialized nurse practitioner, or visiting nurse. Encounters with more than one health professional or multiple contacts with the same professional, in the same day, and in the same location, for the same diagnosis constitute a single encounter. The exception is when a participant, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis and treatment. No shows or visits to pick up medication are not considered an encounter.

> **Note:**   Mental health encounters do not count toward the Medicaid Basic Plan participants 26 services per year limit.

3.2.4 Advance Directives

An advance directive explains to a participant their right to accept or refuse medical services, or to choose among available medical services. The provider will inform the participant of their right to formulate advance directives, such as Living Will and/or Durable Power of Attorney for Health Care. Medicaid has directed that providers of home health care (including federally qualified health clinics, and rural health clinics) must provide all adult Medicaid participants with advance directive information in an understandable format.

If a participant is unable to read the information, the information is read to the participant by a relative or friend. If no one else is available, the provider must read the advance directive information to the participant. If the provider is unable to abide by the medical desires of the participant, the provider is required to assist the participant in finding an alternative source of service.

3.2.5 Procedure Code

- Idaho Medicaid uses federally mandated HCPCS codes. All rural health clinics must use procedure code **T1015** for all services.

- Child wellness exams: See *Section 3.2.8 Child Wellness Exams*, for more information.

- Family planning services: See *Section 3.2.9 Family Planning*, for more information.

3.2.6 Medicare Crossover

Participants may be dually eligible for Medicare and Medicaid. The provider must first bill Medicare for rendered services. A copy of the Medicare remittance notice (MRN) must be included with the Medicaid claim when billing on paper. If billing electronically, the information from Medicare must be entered on the appropriate screens.

If a person is eligible for both Medicare and Medicaid, Medicaid's payment for services will not exceed the amount allowed by Medicaid minus Medicare's payment for those services.

See *Section 2.5 Crossover Claims, General Billing Information*, for more information.

3.2.7 Place of Service (POS) Code

Enter **72** (Rural Health Services) code in the POS field on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.2.8 Child Wellness Exams

Child wellness encounters should be billed as a medical encounter using procedure code **T1015**. Report with diagnosis ICD-9 code **V20.1** – Other healthy infant or child receiving care, or **V20.2 –** Routine infant or child health check, to show that the encounter is a well baby or child examination and to satisfy federal reporting requirements.

Complete information regarding child wellness exams is located in *Section 1.6 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), General Provider & Participant Information*. Sometimes child wellness exams are referred to as EPSDT screen**.**

3.2.9 Family Planning

All claims for services or supplies that are provided as part of a family planning visit must include the FP (Family Planning) modifier with encounter code **T1015**.

Additionally, any family planning encounters should include one of the diagnoses listed in the table below as the primary diagnosis.

Diagnosis Code	Description
V25.01	Prescription of oral contraceptive.
V25.02	Initiation of other contraceptive measure (fitting of diaphragm, prescription of foams, creams, other agents).
V25.09	Family planning advice (other).
V25.1	Insertion of intrauterine contraceptive device.
V25.2	Sterilization (admission).
V25.40	Contraceptive surveillance, unspecified.
V25.41	Contraceptive pill surveillance.
V25.42	Intrauterine device (IUD) (checking, reinsertion, or removal of device) surveillance.
V25.43	Implantable subdermal contraceptive surveillance.
V25.49	Surveillance of other contraceptive method.
V25.5	Insertion of implantable subdermal contraceptive.
V25.8	Other specified contraceptive management (post-vasectomy sperm count).
V25.9	Unspecified contraceptive management.

3.3   District Health Department Services

3.3.1 Overview

District health departments providing services to Medicaid participants usually have more than one provider number. This depends on what services the individual offices provide. If a physician is performing the service, the claim must be submitted under the physician's provider number. If a mid-level practitioner performs the services, this must be billed under the appropriate mid-level practitioner provider number. Always use the appropriate Medicaid provider number when billing Medicaid for services.

Only physicians, nurse practitioners, advanced practice professional nurses, and physician assistants may bill district health services with the CPT procedure codes. Billing for the services provided by a CRNA, NP, NM, or PA must not be represented as a physician service.

This section is specific to services for which the district health department can bill Medicaid. These include family planning, pregnant women (PW) clinic, EPSDT services, and immunizations.

3.3.1.1   Reporting National Drug Code (NDC) for Medications Billed with HCPCS Code J3490

Professional claims for medications reported with HCPCS **J3490** (Unclassified Drug*)*, must include the appropriate NDC, units dispensed, and basis of measurement for each medication billed. This requirement applies to professional claims submitted electronically and on CMS-1500 claim forms. Claims with incomplete NDC information will be denied.

Electronic Claims: To enter NDC data into the PES software, choose the Service 3 tab and enter a Y in the Rx indicator field. A pop-up window will open which allows providers to enter the NDC number, units dispensed, and basis of measurement information. Refer to the *Provider Electronic Solutions (PES) Handbook*, *837 Professional – Rx Instructions* for more information.

Paper Claims: Submission of NDC Detail Attachment is required with paper claim forms when submitting a medication billed with HCPCS **J3490**. For each medication HCPCS code, complete the corresponding detail line on the attachment with the NDC number, units dispensed, and basis of measurement. A copy of the NDC Detail Attachment can be found in *Appendix D; Forms*. Use it as a master copy. Providers can avoid filling out an attachment by submitting their claims electronically.

http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3438/DesktopDefault.aspx

3.3.2 Family Planning Services

3.3.2.1   Overview

Family planning includes counseling and medical services provided by a district health department. Specific items covered are services for diagnosis, treatment, and related counseling.

3.3.2.2   Contraceptive Supplies

Medicaid will pay for contraceptive supplies including prescription diaphragms, IUDs, implants, injections, contraceptive patches, and oral contraceptives.

> **Note:**   The Morning After Pill, Plan B, is not covered.

> **Note:**   IUDs are covered once every rolling five years.

3.3.2.3   Procedure Codes

All claims for services or supplies that are provided as part of a family planning visit must include the **FP** (Family Planning) modifier with one or more of the following CPT or HCPCS codes.

CPT Code	Description
99201	Office or other outpatient visit, new patient (Family planning, brief exam)
99203	Office or other outpatient visit, new patient (Family planning, interim visit)
99204	Office or other outpatient visit, new patient (Family planning, yearly visit)
99211	Office or other outpatient visit, established patient (Family planning, brief exam)
99213	Office or other outpatient visit, established patient (Family planning, interim visit)
99214	Office or other outpatient visit, established patient (Family planning, yearly visit)

Supply Code	Description
S4993	Contraceptive pills for birth control (monthly supply).
J1055	Medroxyprogesterone acetate injection for contraceptive use, 50 mg (Depo-Provera).
J1056	Medroxyprogesterone acetate/estradiol cypionate injection, 5 mg/25 mg (Lunelle).
J7300	Intrauterine copper contraceptive (Paragard T380A).
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (Mirena IUD).
J7303	Hormone containing vaginal ring (NuvaRing).
J7304	Contraceptive supply, hormone containing patch, each (Ortho-Evra patch).
J7306	Levonorgestrel (contraceptive) implant system, including implants and supplies.
A4266	Diaphragm for contraceptive use.
See *Section 3.3.1.1 Reporting National Drug Code (NDC) for Medications Billed with HCPCS Code J3490,* for billing guidelines on medications reported with HCPCS **J3490** (Unclassified Drug).	

Procedures Code	Description (Only allowable to physicians, physician assistants, and nurse practitioners.)
58300	Insertion of IUD.
58301	Removal of IUD.
11975	Insertion, implantable contraceptive capsules.
11976	Removal, implantable contraceptive capsules.

3.3.2.4   Diagnosis Codes

Any family planning service(s) should include one of the diagnoses listed in the table below as the primary diagnosis.

Diagnosis Code	Description
V25.01	Prescription of oral contraceptive.
V25.02	Initiation of other contraceptive measure (fitting of diaphragm, prescription of foams, creams, other agents).
V25.09	Family planning advice (other).
V25.1	Insertion of IUD.
V25.2	Sterilization (admission).
V25.40	Contraceptive surveillance, unspecified.
V25.41	Contraceptive pill surveillance.
V25.42	IUD (checking, reinsertion, or removal of device) surveillance.

Diagnosis Code	Description
V25.43	Implantable subdermal contraceptive surveillance.
V25.49	Surveillance of other contraceptive method.
V25.5	Insertion of implantable subdermal contraceptive.
V25.8	Other specified contraceptive management (post-vasectomy sperm count).
V25.9	Unspecified contraceptive management.

3.3.3 Child Wellness Exams

Complete information regarding child wellness exams is located in *Section 1.6 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), General Provider & Participant Information.* Occasionally child wellness exams are referred to as EPSDT screens.

3.3.4 Immunization Program

3.3.4.1   Overview

Most vaccines provided come through the Vaccines for Children (VFC) Program from DHW, Division of Health. However, on limited occasions, the district must purchase vaccines. Vaccine administration should conform to the Advisory Committee on Immunization Practices (ACIP) guidelines for vaccine use.

When billing for a participant who has both private insurance and Medicaid, bill the private insurance first using its billing instructions. After receiving the explanation of benefits (EOB) from the primary insurance indicating partial or no payment, submit the EOB with the claim to Medicaid using the instructions below. All vaccine services should be billed at the usual and customary rate providers use to bill for non-Medicaid patients.

Vaccine Services Provided	Billing Instructions for Children (The free vaccine program is available for participants until their 19th birthday.)	Billing Instructions for Adults (Free vaccine is not available for those who have reached their 19th birthday.)
Administration of free vaccine only	Bill the appropriate CPT code for the vaccine(s) using modifier **SL** with a zero dollar ($0.00) amount. The CPT code in the range of **90465** to **90474** that accurately reflects the administration of the vaccine(s).	Not applicable, there is no free vaccine program for adults.
Administration of free vaccine and if there is a significant, separately identifiable service, evaluation and management (E/M) visit	Bill the appropriate CPT code for the vaccine(s) using modifier **SL** with a zero dollar ($0.00) amount. The CPT code in the range of **90465** to **90474** that accurately reflects the administration of the vaccine(s). The appropriate CPT code for the E/M visit with modifier **25**.	Not applicable, there is no free vaccine program for adults.
Administration of provider purchased vaccine only	Bill the appropriate CPT code for the vaccine(s) without a modifier. The CPT code in the range of **90465** to **90474** that accurately reflects the administration of the vaccine.	Bill the appropriate CPT code for the vaccine(s) without a modifier. The CPT code in the range of **90471** to **90474** that accurately reflects the administration of the vaccine.

Vaccine Services Provided	Billing Instructions for Children (The free vaccine program is available for participants until their 19th birthday.)	Billing Instructions for Adults (Free vaccine is not available for those who have reached their 19th birthday.)
Administration of provider purchased vaccine, and if there is a significant, separately identifiable service evaluation and management (E/M) visit	Bill the appropriate CPT code for the vaccine(s) without a modifier. The CPT code in the range of **90465** to **90474** that accurately reflects the administration of the vaccine. The appropriate CPT code for the E/M visit with modifier **25**.	Bill the appropriate CPT code for the vaccine(s) without a modifier. The CPT code in the range of **90471** to **90474** that accurately reflects the administration of the vaccine. The appropriate CPT code for the E/M visit with modifier **25**.

Note: Effective February 1, 2007, claims with the **U7** modifier will be denied.

Medicaid should be billed for the administration of state-supplied vaccines according to the service(s) rendered at the time the vaccine(s) was administered. Medicaid uses the most current version of the *Current Procedural Terminology (CPT)* guidelines. For vaccines provided through the VFC Program. Bill with the current CPT code along with an **SL** modifier.

3.3.4.2   Administration, only of a Provider, Purchased Injectable/Vaccine to a Participant with Medicare or Other Primary Payer and Medicaid

When billing for a participant who has both Medicare or private insurance and Medicaid, bill Medicare/private insurance first using its billing instructions. If Medicare or the other primary payer combines payment for the administration with the cost of the injectable, a separate administration fee may not be charged.

3.3.4.3   Administration of an Injection that is Part of a Procedure

Medicaid will not pay the administration fee when an injection is administered that is part of a procedure (*e.g.*, allergy injections, therapeutic and diagnostic radiology, etc.).

3.3.5 Pregnant Women (PW) Clinic

Some district health departments are also PW clinics. They must be Medicaid approved providers and meet the conditions for presumptive eligibility (PE) of pregnant women. A special agreement is signed between DHW and the district health department. The district health department should only utilize personnel who have attended a DHW sponsored training program for PE qualified providers. Approved providers must be trained and certified by DHW.

The procedure codes listed below should be billed under the PW clinic provider number.

Note: Some codes will require a **U5** (PW Program) modifier to be attached to the appropriate HCPCS code.

HCPCS	Modifier Needed	Description
G9001	None	Coordinated care fee, initial rate. (POC development/submittal.)
G9005	None	Coordinated care fee, risk adjusted maintenance. (Risk reduction follow-up.)
S9123	U5	Nursing care, in the home, by registered nurse, per hour. (PW nursing services, home.)
S9127	U5	Social work visit, in the home, per diem. (Individual and family social services.)
S9470	U5	Nutritional counseling, dietitian visit. (PW nutrition services.)

HCPCS	Modifier Needed	Description
T1001	U5	Nursing assessment/evaluation. (PW maternity nursing services.)
T1023	U5	Screening to determine the appropriateness of consideration for an individual that participates in a specified program, project, or treatment protocol, per encounter. (Determination of PE.)

3.3.6 Sexually Transmitted Disease (STD) Clinics

3.3.6.1   Overview

District health departments bill for STD services using their physician or physician extender provider numbers. Services that are free of charge to the general public cannot be billed to Medicaid. Payment is allowed if a sliding fee schedule is used.

3.3.6.2   Payment

Services should be billed using the proper CPT codes for E/M, treatment, and diagnostic services. Usual and customary charges should be used.

3.4   Claim Billing

3.4.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

>   **Note:**   All claims must be received within 12 months (365 days) of the date of service.

3.4.2 Electronic Claims

For PES software billing questions, consult the *Idaho Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2.2.1 Electronic Claim Submission*, *General Billing Information*, for more information.

3.4.2.1   Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail Lines: Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transactions.

Referral Number: A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a HC participant. For HC participants, enter the provider's 9-digit HC referral number.

Prior Authorization (PA) Numbers: Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the claim.

Modifiers: Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transaction.

Diagnosis Codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transaction.

National Drug Code (NDC) information with HCPCS and CPT Codes: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See *Section 3.18.6.3 Physician Guidelines,* for more information.

Electronic Crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for professional services.

3.4.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2006 is entered as 07042006.

3.4.3.1   How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.

- Print legibly using black ink or use a typewriter.

- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.

- Keep claim form clean. Use correction tape to cover errors.

- Enter all dates using the month, day, century, and year (MMDDCCYY) format. Note that in field **24A** (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field **24A**.

- You can bill with a date span (From and To Dates of Service) **only if** the service was provided every consecutive day within the span.

- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.

- Be sure to sign the form in the correct field. Claims will be returned that are not signed unless EDS has a signature-on-file.

- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.

- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

- Only one PA number is allowed for paper claims.

- When billing medications with HCPCS/CPT codes, an NDC Detail Attachment must be filled out and sent with the claim.

3.4.3.2   Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.4.3.3   Completing Specific Fields of CMS-1500

Consult the, Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Note: Claim information should not be entered in the shaded areas of each detail unless specific instructions have been given to do so.

Field	Field Name	Use	Directions
1a	Insured's ID Number	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it appears on the MAID card.
2	Patient's Name (Last Name, First Name, Middle Initial)	Required	Enter the participant's name exactly as it is spelled on the MAID card. Be sure to enter the last name first, followed by the first name, and middle initial.

Field	Field Name	Use	Directions
9a	Other Insured's Policy or Group Number	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required, if applicable	Required if field **11d** is marked yes.
9d	Insurance Plan Name or Program Name	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Patient' Condition Related to Employment?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	Is Patient' Condition Related to Auto Accident?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	Is Patient' Condition Related to Other Accident?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items **9a** - **9d**.
14	Date of Current: Illness, Injury, or Pregnancy (LMP)	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness Give First Date	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required, if applicable	Use this field when billing for a consultation or HC participant. Enter the referring physician's name.
17a	Blank Field	Required, if applicable	Use this field when billing for consultations or HC participants. For consultations enter the qualifier **1D** followed by the referring physician's 9-digit Idaho Medicaid provider number. For HC participants, enter the qualifier **1D** followed by the 9-digit HC referral number. **Note**: The HC referral number is not required on Medicare crossover claims.
17b	NPI	Not required	Enter the referring provider's 10-digit national provider identifier (NPI) number. **Note:** The NPI number, sent on paper claims, will not be used for claims processing.
19	Reserved for Local Use	Required, if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the internal control number (ICN) of previous claims to establish timely filing.
21 (1 - 4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate *ICD-9-CM* code (up to four) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the *ICD-9-CM* primary and, if applicable, second, third, and fourth diagnosis.

Field	Field Name	Use	Directions
23	Prior Authorization Number	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.
24A	Date(s) of Service From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24C	EMG	Required, if applicable	If the services performed are related to an emergency, mark this field with an X.
24D 1	Procedures, Services, or Supplies CPT/HCPCS	Required	Enter the appropriate 5-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Procedures, Services, or Supplies Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Pointer	Required	Use the number of the subfield (**1** - **4**) for the diagnosis code entered in field **21**.
24F	$ Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT Family Plan	Required, if applicable	Not required unless applicable. If the services performed constitute an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program screen. See *Section 1.6 EPSDT* for more information.
24I	ID Qual	Required, if legacy ID	Enter qualifier **1D** followed by the 9-digit Idaho Medicaid provider number in **24J**.
24J	Rendering Provider ID #	Required, if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the **1D** qualifier was entered in **24I**. **Note:** If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID # field. **Note:** Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	Total Charge	Required	The total charge entered should be equal to all of the charges for each detail line.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Balance due should be the difference between the total charges minus any amount entered in the amount paid field.
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See *Section 1.1.4 Signature-on-File Form*, for more information.

Field	Field Name	Use	Directions
33	Billing Provider Info & Ph	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or remittance advice (RA). **Note:** If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the provider master file can be updated.
33A	NPI	Desired, but not required	Enter the 10-digit NPI number of the billing provider. **Note:** NPI numbers, sent on paper claims are optional and will not be used for claims processing.
33B	Blank Field	Required	Enter the qualifier **1D** followed by the provider's 9-digit Idaho Medicaid provider number. **Note:** All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.4.3.4　Sample Paper Claim Form